

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Missouri Pacific Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **179**
(If outside city or town limits, write "RURAL") **99**
(d) Street No. **4401 Clarence Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James Patrick Goodwin**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **488-09-153**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Margaret B. Goodwin** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **July 26, 1874**
(Month) (Day) (Year)

8. AGE: Years **69** Months **2** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Printer**

11. Industry or business

MOTHER FATHER { 12. Name **James Goodwin**
13. Birthplace _____
14. Maiden name **Catherine Nagel**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Goodwin**
(b) Address **4401 Clarence Ave.**

17. (a) Burial (b) Date thereof **10/21/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**
18. (a) Signature of funeral director **Stroot-Carroll**
(b) Address **4600 Natural Bridge Ave.**

19. (a) **OCT 20 1943** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19**
year **1943** hour **2** minute **30** AM

21. I hereby certify that I attended the deceased from **Oct 7**
19**43**, to **Oct 19**, 19**43**
that I last saw him alive on **Oct 18**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary atherosclerosis**

Due to **Chronic myocarditis**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **93**

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W.P. Elmer** (M. D. or other) _____
Address **601 University Club Bldg** Date signed **10/19/43**

Duration

11 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Sheldon Collins

Licensed Embalmer No. 3382

P. O. Address:

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.